COUNTY MEDICAL SERVICES PROGRAM
NOTICE OF ACTION
DENIAL/DISCONTINUANCE OF BENEFITS

(COUNTY STAMP)

Case number: _____

District: _____

Denial/discontinuance for: _____

_____
(Names)

We have reviewed all information available to us about your circumstances, and we find that:

❒ Your application for CMSP dated _____ has been denied.
(Month) (Day) (Year)

❒ Your eligibility to receive CMSP will be discontinued effective the last day of _____.
(Month)

The reason for this denial/discontinuance is:

The regulations which require this action are California Administrative Code, Title 17, Section 1498, et seq.

If you have any questions about this action, or if there are additional facts relating to your circumstances which you have not reported to us, please write or telephone. We will answer your questions or make an appointment to see you in person. Please remember that this action pertains only to the circumstances you reported to us and that you may reapply at any time.

_____ _____ _____
Eligibility Worker Phone Date

APPLICANT COPY
CASE COPY